Equality, Diversity, Cohesion and Integration Impact Assessment

Appendix 3

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration. In all appropriate instances we will need to carry out an equality, diversity, cohesion and integration impact assessment.

This form:

- can be used to prompt discussion when carrying out your impact assessment
- should be completed either during the assessment process or following completion of the assessment
- should include a brief explanation where a section is not applicable

Directorate: Office of the Director of Public Health	**Service area: Locality Public Health Teams**
Lead person: **Liz Bailey**	**Contact number: 0113-3367641**
Date of the equality, diversity, cohesion and integration impact assessment: Updated for Stage 2 December 2015	

1. Title: Re-commission of the 'Locality Community Health Development/Improvement Contracts

Is this a:

	Strategy /Policy	√	**Service / Function**		**Other**

If other, please specify

2. Members of the assessment team:

Name	**Organisation**	**Role on assessment team e.g. service user, manager of service, specialist**
Liz Bailey	LCC	Project Team Lead (ENE Leeds)
Jon Hindley	LCC	Project team member (WNW Leeds)
Rachel Brighton	LCC	Project team member (S & SE Leeds)
Kate Daly	LCC	Project Team Public Health Contracts Officer
Roxanna Summers	LCC	Equality and Diversity Support
Shazia Nazir	LCC	Project Support Officer
Pauline Ellis	LCC	Senior E & D Officer, Policy & Performance

3. Summary of strategy, policy, service or function that was assessed:

The LCC Public Health commissioned Locality Community Health Development/Improvement contracts have been operating in deprived communities of Leeds for a number of years. A review, which is informing the re-commissioning of this service, has been completed.

The overarching aim of the contracts is to: improve the health of the poorest fastest and thereby:

Reduce the difference in healthy life expectancy between communities through tackling the wider determinants of health and supporting people to live healthier lifestyles, focusing especially on those that are most vulnerable and / or live in the more deprived areas of the city.

The review provided information to help us to secure a future service that is based on:

- A fair process for existing and other organisations (all of whom to support equality groups) to bid to provide services, in line with the Council's rules;
- Learning from what has been going well and what works, both in Leeds and elsewhere, so that services can become more effective and efficient
- Making sure our services are focussed on supporting those people and communities most in need, taking into account any demographic or other changes, and considering how we can encourage greater local responsiveness to local needs during the duration of any new contracts
- A continuing focus on reducing the health inequality gap and ensuring that those who are the poorest improve their health the fastest
- Improved consistency of standards across the city
- Improved and embedded robust outcome measurement, monitoring and management process
- Incorporate value for money as defined by HM Treasury i.e. the optimum combination of whole-of-life costs and quality (or fitness for purpose) of the good or service to meet the users requirement. Value for money is not the choice of goods and services based on the lowest cost bid (HM Treasury 2006). The project team have agreed a split of 60% quality and 40% price.
- Making sure the new contracts are fit for purpose, linking well with and adding value to other commissioned services and programmes. For example the Clinical Commissioning Groups are funding Third sector grants and social prescribing activity and other parts of Public Health fund e.g. Community Health Educators or community cancer screening awareness. We want to make sure that all this work is complementary, eliminates risk of duplication in public health activity and sustains future community public health capacity.

The equality impact assessment has assessed current practice, taken into account access by equality groups, identified gaps in service, geographical reach and barriers to access and is using this to take steps to build remedial action into the service specification, in order to design a more inclusive future service model.

The full range of equality characteristics which were considered are detailed below:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.
- Poverty and health and wellbeing

4. Scope of the equality, diversity, cohesion and integration impact assessment
(complete - 4a. if you are assessing a strategy, policy or plan and 4b. if you are assessing a service, function or event)

4a. Strategy, policy or plan (please tick the appropriate box below)	
The vision and themes, objectives or outcomes	☐
The vision and themes, objectives or outcomes and the supporting guidance	☐
A specific section within the strategy, policy or plan	☐
Please provide detail: N/A	

4b. Service, function, event please tick the appropriate box below	
The whole service (including service provision and employment)	√
A specific part of the service (including service provision or employment or a specific section of the service)	☐
Procuring of a service (by contract or grant)	√

Please provide detail:

A review of the current service, which consists of 14 contracts delivered by 11 different organisations, has helped us understand who currently accesses the services and some reasons why people do and don't. We are using this understanding together with comprehensive demographic data, provider, stakeholder and community consultation information to help us design and procure an inclusive service for the future.

As well as the positive impacts detailed above, the re-commissioning of the service could result in potential negative impacts, including:

- Future employment implications- some of the current third sector providers employ local people, and certainly recruit volunteers from the deprived area in which they work. Any cuts to funding, or different providers securing the contract, could affect training and development opportunities, employment and income for local people.
- There is a risk that a new service, by new providers is not familiar or acceptable to local people, which could result in low usage.
  Some of the current providers are small enough to respond well to community needs, but they may not be large enough to compete effectively in the LCC tendering process, potentially meaning

community needs remain unmet

5. Fact finding – what do we already know

Make a note here of all information you will be using to carry out this assessment. This could include: previous consultation, involvement, research, results from perception surveys, equality monitoring and customer/ staff feedback.

(priority should be given to equality, diversity, cohesion and integration related information)

During the review process, available data sets were used to build a picture of current population needs and levels of access to the current service by equality groups, in order to meet those needs. Provider monitoring information, annual reports, provider and stakeholder events, user and citizen questionnaires/ focus group information has been added. Also Census data and other national and local data sets have been analysed.

All current services are contracted to work in priority neighbourhoods that are within the 10% most deprived nationally and consequently target those on the lowest incomes. Some also focus on specific sub population groups, which historically have been in terms of the predominant BME groups, which research tells us have the poorest health. This, together with postal code referencing and equality monitoring, has provided evidence of access by individuals from deprived neighbourhoods, with all the diversity they contain.

We use the equality monitoring data which is returned by providers quarterly, to track access by different priority groups to all the activities, rather than providing targeted activities for e.g. disabled, those with learning difficulties or gay, lesbian and transgender individuals/ communities. We are aware that some of this data is missed by some organisations due to sensitivities/concerns around asking some questions. Gender reassignment, marriage and civil partnership and pregnancy and maternity, are not currently included . There is a separate city wide public health contract which covers Gypsy Travellers, (arguably the most disadvantaged group of all in terms of health inequalities), but the community health improvement contracts monitoring does provide evidence of access by this group as well.

The current service caters for a diverse set of sub communities, each with different histories, capacities and needs. Some live in a particular geography, side by side within a shared neighbourhood, whilst others are geographically dispersed, but may share a common bond through experience, ethnicity, disability, interest etc. Both in the current contracts and in the future, the intention is to reach the poorest and most inaccessible groups, in the most deprived communities so we can improve their health the fastest, close the health inequality gap and improve life expectancy.

The review has identified current and emerging health needs in terms of age, gender, and ethnicity as well as differences between deprived communities and non-deprived communities

Gender

We know that both nationally and locally women are more likely to access health activity, than men. In 2012, the population of Leeds males was 367,900 and 383,600 females. Monitoring of users of the Community health development and improvement contracts during 2014-15 found they were overwhelmingly female (71%) to 29% male users, which doesn't adequately reflect the male female proportions in the general population. However, many of the providers are now responding to this imbalance and specifically targeting men in their activities. This has also been identified as a continuing need in the new contracts.

We are less informed about access to the Community health development and improvement services by transgender individuals and their experience of those services as it is most likely that individuals will identify with, and be recorded under their new gender.

Age
In the coming years, Leeds is expecting to see an increase in the numbers of children of primary school age, which also possibly means an increase in women of child bearing age, as well as increased numbers of those aged over 75 and over 85. Analysis of the Community health development and improvement contracts from 2014-15 showed most users were in the young to middle aged group (40% were 19-40yrs) and 33% were aged 41-65yrs. 18% were in the 65+ group and although no analysis beyond this is possible (i.e. breakdown between 65+ and 74yrs, 75-84yrs or 85+), monitoring returns do seem to suggest that the situation is acceptable, both to commissioner and users.

Older people, who access the services, do appear to be well catered for and according to monitoring data, access the service activities e.g. health walks, modern technology awareness, gardening groups, tea dances etc. These provide respite from loneliness, help functioning in the modern world and improve mental, as well as physical health. Whilst it is possible that older people who live in outer rural locations, may not be able to travel easily to these projects, the outer, more affluent areas are not included in our target audience. Although citizen questionnaires showed a perception amongst younger groups that older people are not well catered for and many respondents said that children's activities could be better, children who gave their views during the consultation were very positive about the range of activities that were on offer in their local areas.

Race
The most recent census (2011) indicates that the Leeds population has grown 5% since 2001 and is a diverse city, with over 140 ethnic groups including Black, Asian and other minority ethnic populations representing almost 19% of the total population.

Almost 93% of people across Leeds have English as their main language, but just over 51,000 (7.1%) reported a main language that was not English. Polish was the most popular (6,717) people, Urdu (4,989) and Panjabi (4,537) people. (Census 2011 Migration doc). In schools, 15 000 pupils in Leeds have a first language that is not English. This is equivalent to 18% of primary and 13% of secondary pupils.

The Leeds' non-UK born population is now 14%, higher than the Yorkshire and Humber average of 9% Non-UK born residents have settled particularly in Gipton and Harehills, City and Hunslet, and Hyde Park and Woodhouse wards. Gipton and Harehills ward is the first in the city where the BME population is in the majority (2011 Census).

In terms of access by BME groups, the majority of users of the CHIDS were White (62%), with 20% Asian or Asian British, 10% Black or Black British, 5% mixed/multiple ethnic group and the smallest number (2%) other ethnic groups.

Whilst many current service providers are well geared to meeting the needs of long established groups such as South Asian and African Caribbean, they have recently reported challenges around the language and cultural needs of some of the newly emerging communities. Interpretation and translation services are expensive (£40 per hour) and whilst many providers report that ESOL classes are very effective in helping people understand, they feel there are insufficient classes to meet increasing need and it takes considerable time to learn a new language well enough to improve health understanding, adapt to appropriate service use and integrate fully into their community. Other language and cultural impacts being reported include sanctions being applied for non-compliance around job seeking, inappropriate use of primary and secondary care and poor understanding around mental health/mental health services.

Religion
In terms of religion, the majority of people accessing the CHIDS during 2014-15 were Christian (42%) and the next largest group Muslim (41%). 14% of people did not state their religion and 1% Hindu and 1% Sikh users were recorded. This category will be continued to be monitored in the new contracts.

Poverty and Health and Wellbeing
In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods. The average difference in disability free life expectancy is 17 years. So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives living with impairments. This finding is reflected in Leeds statistics and although overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds (Leeds Joint Health and Wellbeing Strategy 2013-15).

Current providers have historically tailored activities to meet the needs of those on very low incomes, the whole rationale behind this work, but many are reporting that the welfare reforms have resulted in an increase in families who are so impoverished, that focus often has to switch from health promotion, to crisis intervention work.

All providers are required to record postcode data, which shows they are providing an accessible service to neighbourhoods within the 10% most deprived nationally. As deprivation is still a huge challenge, particularly in inner city neighbourhoods, this needs to continue as a requirement into the new contract.

Sexual Orientation
We are less informed about access to the Community Health Improvement services by individuals who are lesbian gay or bi-sexual and although sexual orientation is included in current provider monitoring returns, most people have identified as heterosexual (99%), or prefer not to say.

It is difficult to determine if this is a free choice, because they prefer the tightly knit and specialised support of other Lesbian, Gay or Bisexual people and the anonymity of services outside their neighbourhood, or a perception (imagined or real) that local services are not accessible to them. Local intelligence suggests that individuals from some newly emerging communities, where non heterosexual orientation is rejected, may choose not to answer this question, for fear of reprisal within their own community.

In Leeds generally, there is evidence of more mental health support available for LGBT people than in the past, and mainstream services are becoming more welcoming and accessible.

Evidence suggests that although the majority of LGB people do not experience poor mental health, some LGB people are at higher risk of mental disorder, suicidal behaviour and substance misuse. It also indicates that the increased risk of mental disorder in LGB people is linked to experiences of discrimination. LGB people are more likely to report both daily and lifetime discrimination than heterosexual people and higher rates of anxiety and depression than heterosexuals.

Gay men and bisexual people are significantly more likely to say that they have been fi red unfairly from their job because of discrimination and discrimination has been shown to be linked to an increase in deliberate self-harm in LGB people.

Lesbians are more likely to have experienced verbal and physical intimidation than heterosexual women and together, lesbians and bisexual women may be at more risk of substance dependency than other women. Lesbian, Gay and Bisexual people have also been shown to be at greater risk of deliberate self-harm.

One-third of gay men, a quarter of bisexual men and over 40% of lesbians reported negative or mixed reactions from mental health professionals, when they disclosed their sexual orientation and one in five lesbians and gay men and a third of bisexual men stated that a mental health professional made a causal link between their sexual orientation and their mental health problem.
(DOH Briefing No 9, 2007).

Monitoring is a key tool, in order to be able to respond to the needs of Lesbian, Gay and Bisexual

individuals in the city, but providers often fail to use it, due to lack of understanding of its importance, or reluctance on the part of staff to ask what they feel are inappropriate questions (Volition 2014).

One current Community development and health improvement service provider provider has tried to rectify this by providing staff training and have recently reported that staff are now more confident to ask and users to provide this information. This good practice will be considered and to aid consistency across the wedges reflected in the service specification of the new service.

Disabled groups
26% of users were recorded as disabled and this seems to suggest that the service is accessible to this group, although this may not apply to all disabled groups. The majority of providers are showing a proportion of people with mental health impairments and physical impairments accessing the service.

Carers
Only 2% of users who accessed the Community health development and improvement service in the 12 months up to the review were described on monitoring returns as carers, so this may suggest limited access by this group, which needs to be addressed. However, this equated to 200 people and Carers Leeds do provide a substantial dedicated service for this group of people (including male carers). Very recently a Carers group, facilitated by Leeds North CCG has been set up and advertised. This is welcomed, as it is possible that some carers may have little support in their local neighbourhood. More research around this will need to be done around this, utilising other data such as the internal complements and complaints system, citizen surveys and consulting with other commissioners around specification design.

Currently the service does not ask for information around marital or civil partner status. This may need to be considered in the new contracts.

Are there any gaps in equality and diversity information Please provide detail:

Because we have low figures in terms of responses to the sexual orientation monitoring questions in our returns, our local knowledge as to reasons is limited. It is difficult to assess if this is a true reflection of the numbers of that particular group locally, if they prefer to access services elsewhere, or if some are accessing the activities, without disclosing status.

However, it does not appear that the questions are not being asked as during the 2014/15 period, 3,480 heterosexual individuals were recorded, 10 gay, 11 lesbian and 6 bi-sexual individuals. Rather, it could be the low numbers of this equality group using the service, or disclosing, as in the same period 200 carers were identified and 2051 disabled individuals accessed the service.

There may be a gap in terms of newly arrived communities. This could be because of language barriers, lack of confidence, poor understanding or perhaps in some cases a wish to preserve anonymity.

As commissioners, we do not currently ask for data on gender reassignment , civil partnership arrangements, or pregnancy and maternity, but from monitoring information we do know that pregnant women are frequently targeted and supported in terms of e.g. parentcraft sessions, walking groups and healthy eating groups/activities. As long as they are aware of the service activities, access by this group does not appear to be a problem.

In terms of the new contracts, it will be imperative that the providers can demonstrate how they will continually monitor access by the relevant equality groups and also how they are responsive to continually changing demographics and the subsequent needs of new communities.

Action required:

1. **Review Process**

The review has considered issues arising from the evidence reviewed, examined the accessibility of projects

to equality groups, and the consultation has included diversity considerations in terms of monitoring data, annual report examination, provider questions, stakeholder views and sampling of community respondents.

2. Service specification

This assessment, including the findings in the literature review, Health Needs Assessment and review process has highlighted a number of considerations, which will now be used to ensure that the new service specification and on-going monitoring arrangements in the new contracts are showing due regard to equality.

3. Ensure training provided.

One of the current provider organisations has reported that recent staff training has led to staff members being more confident around asking for information and a noticeable increase in the number of users willing to provide information around sexuality. This provider is the only one which has recorded bi-sexual users (6) accessing the service and recorded the second highest number of lesbian users (3). We will require the new providers to undergo this, or similar training, approved by Leeds City Council to ensure we can better track and address usage of the health improvement and development service by different sexual orientation groups.

There is likely to be an underestimation of access by transgender individuals as although some may identify themselves as such, perhaps in the change process it is expected that once through the process, they will state their new gender.

As a minimum, all providers will be required to adhere to the Leeds City Council equality and diversity policy and adopt its good practice.

4. On-going consultation by providers

We will ensure that the new contracts build in on-going consultation by the providers to ensure that they regularly test, assess, investigate and respond to apparent low usage of the service by any equality groups and that they strive to ensure staff teams, as far as possible are reflective of the communities they serve.

6. Wider involvement – have you involved groups of people who are most likely to be affected or interested

[x] **Yes** [ ] **No**

Please provide detail:

We have run a number of stakeholder consultation events, including, public health colleagues, other council colleagues, current providers, user groups and also done some street consultation with the local community, to gain their perceptions of the current service, identify gaps and ask views around what a good service would look like. However, in the interests of expediency, cost and lack of privacy in the street, whilst efforts were made to obtain a balance in terms of age, gender, ethnicity and disability, the community consultation was not set up to systematically seek out every equality group, it being assumed that individuals could provide an objective view, based on their personal experience, regardless of this.

Out of 20 people opportunistically questioned in Chapeltown and Harehills, the diversity of the local community and hence the need for the new contracts to be able to meet the needs of this population was well demonstrated. 1 person declined to participate because a non-English speaker and 1 declined to answer the ethnic grouping question. A mix of English (2), British (1), Any other white (Czech) 1, Pakistani (1), Indian (2) Bangladeshi (1) White and Black African (3) African (2) Black or Black British Carribean (3) White and Black Carribean (3).

In West Leeds, 16 people (12 females and 4 males) were consulted. Of those providing ethnicity data there were 7 White 2 African 2 Asian: 2 Polish and 1 mixed/multiple ethnic group.

Action required:

1. Findings from the review and consultations are being fed into developing the model and specification design.

2. To ensure that core equality characteristics and any other relevant characteristics for this service are built into the specification and that future monitoring arrangements capture this equality data.
3. Appropriate training to be put in place to enable delivery partners to build confidence around asking for potentially sensitive information.
3. All providers will be required to adhere to the Leeds City Council Equality and Diversity policy

7. Who may be affected by this activity?
please tick all relevant and significant equality characteristics, stakeholders and barriers that apply to your strategy, policy, service or function

Equality characteristics

X	**Age**	X	**Carers**	X	**Disability**
X	**Gender reassignment**	X	**Race**	X	**Religion or Belief**
X	**Sex (male or female)**	X	**Sexual orientation**		
X	**Other**				

(Other can include – marriage and civil partnership, pregnancy and maternity, and those areas that impact on or relate to equality: tackling poverty and improving health and well-being)
Please specify: tackling poverty and improving health and well-being) pregnancy and maternity

Stakeholders

x	**Services users**	x	**Employees**		**Trade Unions**
x	**Partners**	x	**Members**		**Suppliers**
X					

Other please specify

Other potential providers (Third Sector or other public/private) who could potentially provide the service

Potential barriers.

X	**Built environment**	X	**Location of premises and services**

X	**Information and communication**	X	**Customer care**
X	**Timing**	X	**Stereotypes and assumptions**
X	**Cost**	X	**Consultation and involvement**
X	**Financial exclusion**	X	**Employment and training**

X **specific barriers to the strategy, policy, services or function**

Please specify

Built Environment
The service needs to be delivered where it is accessible to all, including wheelchair users, parents with prams/buggies. Citizen questionnaires also cited the safety aspects (both traffic safety and street safety) issues when designing new services. Dangerous pavements and traffic were considered as important issues to consider.

Information and communication
There is a challenge in terms of information dissemination and communication, particularly with those, whose first language is not English. Translation skills are expensive and using other family members/friends may not be appropriate in some cases e.g. domestic violence issues. This could result in fewer people, who could benefit, accessing the service.

Citizen questionnaires revealed low awareness of current services although it was evident that the closer the service was to the sampling site, the more likely the respondent would recall the service. This shows that the new service needs to advertise widely, frequently, in a suitable channel for the target audience and in a very obvious way.

Timing
Timing of the service to ensure access for working age individuals, parents with school aged children and to enable more vulnerable individuals including impairment groups, learning disabilities and elderly people to travel safely.

Citizen surveys show that timing to accommodate working people and older people is important when the council is developing new service. Also dependent on activity/target audience/community needs, timing should consider school/nursery times to enable families and single parents to participate.

Cost
Recent and future budget reductions could mean that services that are preventive by nature, are not prioritised, current Third Sector providers do not survive and the most vulnerable groups in marginalised communities (both in terms of poverty and community of interest i.e. equality group, that have the poorest health) are not supported to maintain good levels of health and wellbeing.

Financial Exclusion
Local people in deprived areas have little or no disposable income and services need to be free or very low cost. They also need to be locally available as affordability of childcare is an issue for families and single parents. Crèche considerations are important to enable those who are most in need to participate

Location of premises and services
People living in deprived communities are often reliant on having services nearby as travelling can be costly both financially and in terms of time. However, it is important to have services situated so they can be accessed by public transport. Cultural preference also needs to be considered as some e.g. Bangladeshi women prefer activity away from their own community.

Stereo types and assumptions
Within the contract, the providers will be required to treat all people with dignity and respect and not make any stereo typical assumptions that could upset anyone who wishes to access the service.

Consultation and engagement
The review process has comprehensively consulted with a wide cross section of people-those providing current services, service users, potential service users, stakeholders, Public Health and other relevant Leeds City Council colleagues, Elected Members and university colleagues. A snap shot street consultation, which includes a wide range of different ages and ethnicities as well as taking male and female views on board. The new specification will state a requirement for providers to consult regularly with users/potential users to ensure that quality of customer care, and location and timing is acceptable to users of all equality groups, if they wish to use the service.

Addressing financially excluded groups is core business, both now and in the future, so cost of activities, employment and training of staff and volunteers, location of premises and services, will be considered in detail through the service specification.

Employment and training
The review has highlighted potential impacts on local jobs when the service goes out to procurement. If the contract is secured by new provider/s, then staff jobs (who may be local) could be at risk. A need for training staff around collecting equality groups data has also been highlighted.

8. Positive and negative impact

Think about what you are assessing (scope), the fact finding information, the potential positive and negative impact on equality characteristics, stakeholders and the effect of the barriers

8a. Positive impact:

The service review and data analysis of the population needs in our priority neighbourhoods, as well as provider and customer feedback has helped us to identify 'what works' and current gaps in service. It has also helped us to assess demographic trends and the variation in usage by equality groups. This has helped us consider what needs to happen to ensure the future service is able to address currently unmet needs.

For instance, providers have already identified a need to better meet the needs of newly emerging Eastern European communities and others such as African and refugee asylum seeker populations, which have specific cultural needs. Knowing the barriers and learning from those who have adapted practice to help overcome some of the barriers will help us develop a more inclusive and efficient service for the future.

Action required:

1. Use the review findings to build adaptations and flexibility of service to ensure active monitoring/appropriate response to apparent low use by any equality groups into the new specification.
2. Conduct more research to find out why some groups do not appear to be accessing current service
3. Ensure potential providers can demonstrate, how they will deliver an inclusive service in a non-burdensome way

8b. Negative impact:

1. The increasing number of languages and variation in dialect in local communities makes it a challenge to ensure that services are well geared to meeting the needs of all equality groups and this could take efforts away from those groups that have traditionally found the service to meet their needs.

2. Translation costs are expensive and although some family members/friends have in the past been asked be asked to translate, it is not always appropriate when dealing with sensitive issues e.g. domestic violence, mental health, post- traumatic stress syndrome, lasting effects of torture or financial issues. These are issues that are routinely presented to our Third sector partners.

3. Fact finding has identified low recorded usage of the current service by carers and by a number of sexual orientation groups

4. If we were to add further categories of equality data, providers may find it burdensome and feel it inappropriate for their target groups. The service needs to see the tangible benefits of the additional activity, rather than it being a purely contractual function.

Action required:

1. Handle sensitively and source training that can help providers collect accurate equality and diversity information about their users
2. More investigative work to be done to find out why some groups are not recorded as accessing current services and what can be put in place to rectify this situation in the new service.

9. Will this activity promote strong and positive relationships between the groups/communities identified?

[X] **Yes** [ ] **No**

Please provide detail:

If groups are more visibly mixed, there is greater potential for community cohesion to increase and social isolation to decrease, positive mental health will be supported and barriers due to lack of understanding of others is likely to decrease.

Action required:

Identify good practice models where diverse groups have worked together. Design specification to ensure different providers can work together, rather than providers focusing only on their separate target group e.g Asian women, or older people

10. Does this activity bring groups/communities into increased contact with each other? (e.g. in schools, neighbourhood, workplace)

[X] **Yes** [ ] **No**

Please provide detail:

The new services will be open to all community members, with the intention that it will encourage strong community relations. This could be further enhanced by increased activity to engage and support other individuals/groups that are more reticent about joining in. The current providers have reported increased joint working and this can benefit both organisation and users, as linkages are made between projects and different users of projects. Mechanisms to encourage this will be by built into the new service specification.

Action required:

Now building into specification

11. Could this activity be perceived as benefiting one group at the expense of another? (e.g. where your activity/decision is aimed at adults could it have an impact on children and young people)

	Yes		No
		X	

Please provide detail:

The service will predominantly targets adults, but as activity is often family focused it will be open to all. As, Cupboard (a young people's project) has been included in South and East Leeds previously, the opportunity to provide activity for young people across all three areas will be included in the new contracts. Providing these services do not mean resource is diverted away from other groups, but thought needs to be given as how to increase and record access by all groups, particularly those that are from newly emerging communities.

Cupboard is currently working only in the South of the city and many community respondents felt that there was a dearth of activities locally for young people (not necessarily borne out by the young people we surveyed). However the opportunity to provide this activity, should it be a need in a particular area is being built into the new specification.

Action required:

Address in specification

12. Equality, diversity, cohesion and integration action plan
(insert all your actions from your assessment here, set timescales, measures and identify a lead person for each action)

Action	**Timescale**	**Measure**	**Lead person**
Ensure any gaps identified in current service review are systematically addressed in the new service specification	Review findings at beginning of September 2015	Use evidence collected during review to inform specification development. Support and challenge sessions will test out ideas to help modify and develop final version	LB
Ensure on-going consultation processes in new service include views from equality groups as to whether service meets their needs, unless these are being met elsewhere e.g. by other services, charities or city wide contracts	Consultation process for review findings began Sept 2015 Specialised services e.g. LIP, MESMAC, Volition and Carers Leeds invited to support and challenge event to gain insight into equality groups not yet consulted	Specification contains appropriate wording to ensure providers are clear about the requirements to ensure that any barriers to access for people with the relevant equality characteristics are removed	LB
Work up detailed plans to address language barriers to help facilitate added value workstreams e.g.JC+, community learning, health protection, appropriate use of public services etc	Nov 2015	Relevant individuals invited to support and challenge event in January, to help work up appropriate clauses in specification Providers to ensure that workforce adequately reflects the demographic make-up of	LB (in specification)

Action	Timescale	Measure	Lead person
		the local community, including access to appropriate community languages	
Ensure new service model is flexible to ensure the needs of communities of interest, especially those of newly arriving individuals can be met more effectively	November 2015	Service specification being developed. Incorporating detailed measures which need to be in place Monitoring arrangements to ensure that providers adhering to service specification and regularly assessed	LB
Provider to achieve the Domestic Violence Quality mark by the end of the first year of the contract.	To be included in the specification by January 2016.	Specification to include this and other relevant quality marks Contract officers to monitor providers to ensure compliance	LB, RB & JH
Provider to recruit staff that is in line with Equalities Act. All recruitment opportunities to be advertised locally as well as nationally including local newspapers.and websites that will encourage diversity.	To be included in the specification by January 2016.	Provider to submit information on where opportunities are advertised Provider to ensure that workforce adequately reflects the composition of the local neighbourhoods	LB, RB & JH
Ensure the collection of data pertinent to equality monitoring by the provider is written into the specification. To be specific on what data is to be	To be included in the specification by January 2016. Equality data to be submitted on a quarterly basis.to enable	Number of individuals taking up the service	LB, RB & JH

Action	Timescale	Measure	Lead person
collected, when it is to be collected, when it will be submitted and the reason for collection. To particularly respond to those categories e.g. carers, Lesbian Gay and Bisexual. and showing low participation in current activity Transgender monitoring issues still being clarified and this project will be guided by LCC Equality Team once policy is clear.	monitoring and responsive action.		
To ensure the venues for service delivery are compliant with the Equalities Act 2010 and venues are accessible to deprived communities e.g. well serviced bus routes,	Throughout the contract period	To monitor where services are delivered from	LB, RB & JH
Patient and Public Involvement (PPI) section to be included in the service specification. An opportunity for service users and non-service users to feedback. Detailing the kind of PPI that is expected including focus groups with equality groups but not exclusively.	To be included in the specification by January 2016. PPI to be submitted on an annual basis.	PPI Report.	LB, RB & JH
Marketing / Communication	To be included in the	A Service leaflet and	LB, RB & JH

Action	Timescale	Measure	Lead person
section to be included into the service specification clearly outlining the need for service information leaflet in line with The Information Standard. Must have communication in different languages.	specification by January 2016.	communication and branding strategy.	
Service Specification to include a section on engagement and access. Key groups to be identified in the specification.	To be included in the specification by January 2016.		LB, RB & JH
Method statement question on communication and engagement in the tender documentation. Tenderers to submit communication plan for the service.	March & July 2016	Evaluated using set criteria.	Project Team
All complaints to be captured and forwarded to the commissioner for review within five days. This will improve service provision and the nature of the complaint will help identify any issues that are impacting on equality. To be included in the specification	Provider to submit all complaints to the commissioner within five days. To be included in the specification by January 2016.	Number of complaints received	LB, RB & JH
All compliments to be captured	Provider to submit all	Number of compliments	LB, RB & JH

Action	Timescale	Measure	Lead person
and forwarded to the commissioner for review within five days. This will improve service provision and the nature of the compliment will help identify any issues that are impacting on equality. To be included in the specification	compliments to the commissioner within five days. To be included in the specification by January 2016.	received	
Ensure the collection of data pertinent to equality monitoring by the provider is written into the specification. To be specific on what data is to be collected, when it is to be collected, when it will be submitted and the reason for collection.	To be included in the specification by January 2016. Equality data to be submitted on a quarterly basis.to enable monitoring and responsive action.	Number of individuals taking up the service.	LB, RB & JH
Customer service requirements to be built into the specification.	To be included in the specification by January 2016	Complaints and compliments.	LB, RB & JH

13. Governance, ownership and approval State here who has approved the actions and outcomes from the equality, diversity, cohesion and integration impact assessment		
Name	Job Title	Date
Lucy Jackson	Consultant in Public Health	28/01/16
Date impact assessment completed 2nd December 2015		

14. Monitoring progress for equality, diversity, cohesion and integration actions (please tick)

x	As part of Service Planning performance monitoring
x	As part of Project monitoring
x	Update report will be agreed and provided to the appropriate board Please specify which board (Public Health Programme Board)
	Other (please specify)

15. Publishing

Though **all** key decisions are required to give due regard to equality the council **only** publishes those related to **Executive Board**, **Full Council, Key Delegated Decisions** or a **Significant Operational Decision.**

A copy of this equality impact assessment should be attached as an appendix to the decision making report:

- Governance Services will publish those relating to Executive Board and Full Council.
- The appropriate directorate will publish those relating to Delegated Decisions and Significant Operational Decisions.
- A copy of all other equality impact assessments that are not to be published should be sent to equalityteam@leeds.gov.uk for record.

Complete the appropriate section below with the date the report and attached assessment was sent:

For Executive Board or Full Council – sent to **Governance Services**	Date sent:
For Delegated Decisions or Significant Operational Decisions – sent to appropriate **Directorate**	Date sent:
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent:
